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RESOLVING CONSUMER GRIEVANCES IN A MANAGED CARE ENVIRONMENT

*Eleanor D. Kinney, J.D., M.P.H.**

I. INTRODUCTION

ONE MUST COME TO THE SUBJECT of resolving consumer grievances in a managed care environment with deep concern that many forces are at work today to disempower consumers in their ability to influence the content and quality of the health care services they receive. Specifically, the number of uninsured Americans continues to increase, from thirty-seven million in the late 1980s¹ to over forty million in 1995.² The number of Americans insured under employer-sponsored health plans has decreased ten percent since 1980 as employers attempted to control their exposure to the escalating costs of employee health care.³ Indeed, the trend in health insurance coverage since 1980 has been to reduce the number of covered individuals, to limit benefits and their coverage, to constrain the choice of providers and services, and to increase individual responsibility for health costs.⁴ The nation's public hospitals that serve the uninsured are threatened with closure as states and the federal government seek to curtail Medicare and Medicaid program expenditures.⁵ Further,

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1. PAMELA F. SHORT ET AL., UNINSURED AMERICANS: A 1987 PROFILE, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND HEALTH CARE TECHNOLOGY ASSESSMENTS (1988).

2. CELIA SILVERMAN ET AL., EMPLOYEE BENEFIT RESEARCH INSTITUTE, EBRI DATABOOK ON EMPLOYEE BENEFITS (Carolyn Pemberton & Deborah Holmes eds., 3d ed. 1995).

3. Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990's*, 21 J.L. MED. & ETHICS 141, 153-54 (1993).

4. See *id.* at 153-55.

5. See Kevin Sack, *Public Hospitals Around Country Cut Basic Service*, N.Y. TIMES,

malpractice reform bills before the 104th Congress would severely limit the ability of plaintiffs to recover for serious medical injuries, or even to get to court to press claims for poor quality, injurious medical care.⁶

Help in the form of government-sponsored health reform is not forthcoming in the foreseeable future. Systemic health reform at the federal level is not in the offing given the failure of Congress to adopt health reform in the 103d Congress and the lack of interest in comprehensive health reform in the 104th Congress. Further, state efforts toward genuine health reform, while holding much promise, have not been universally implemented or sustainable over time.⁷ It is thus especially important to address the issue of consumer grievance resolution in managed care plans, particularly in the current environment of failed health care reform and powerful and effective private moves toward competitive, lower-cost managed care systems.

The health care industry is indeed reorganizing itself at a frenetic pace. Hospitals, physicians, and insurers are engaged in corporate restructuring efforts to develop networks that will maximize revenues for network sponsors. The major mechanism for maximizing such revenues is so-called managed care, in which the cost and utilization of health care services are carefully controlled. Other than utilization review and contract limits on choice and costs, the major means by which care is "managed" is by assigning the risk of excess cost and utilization to the providers directly responsible for providing care to plan members, thereby motivating these providers to limit the care provided. While consistent with theories of competition as an effective means of controlling health care costs,⁸ the upshot of these mechanisms may be to limit the ability of consumers to select both the health care they receive and the providers from whom they receive it.

Aug. 20, 1995, at A1.

6. See Jennifer O'Sullivan, *Congressional Research Serv.*, in *MEDICAL MALPRACTICE* 10 (1995). See Eleanor D. Kinney, *Malpractice Reform in the 1990s: Past Disappointments, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99 (1995) (reviewing malpractice reform proposals before the 103d Congress).

7. COUNCIL FOR AFFORDABLE HEALTH INSURANCE, *HEALTH CARE REFORM IN THE STATES*, 1995 (1995) (discussing state government's efforts to create innovative health care systems).

8. Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF., Supp. 1993, at 24.

This Article addresses how patient grievances can be prevented and/or resolved in public and private managed care plans. First, the Article describes the development of managed care plans in the American health care system and the profound changes in the relationships between patients and physicians in managed care plans. Here, the Article explores the implications of these developments for the prevention and resolution of patient grievances. Second, the Article reviews the existing legal rules that currently govern the resolution of disputes in the health care system as well as the deficiencies of those legal rules for protecting patients with grievances in managed care settings. Third, the Article addresses the critical issues in designing grievance and appeal procedures for resolving disputes among patients, physicians, and managed care plans. Finally, the Article suggests approaches for reducing grievances in managed care settings — ultimately the most effective means of addressing the real needs of patients and their physicians.

II. THE PHENOMENON OF MANAGED CARE

A. Historical Development

Managed care is a broad term that connotes efforts by sponsors of health insurance plans and health maintenance organizations (HMOs) to “manage” the care provided to plan members in order to avoid unnecessary utilization of services and thereby contain expenditures and maximize revenues. Managed care is best understood as an effort to reform the traditional fee-for-service system in which the patient selects a physician; the physician provides or orders the care that, according to the best medical judgment, the physician believes to be appropriate; and the insurer passively pays the resulting bills for the care. Managed care is predicated on the assumption that this system is imperfect because physicians and other providers who are paid for the care have inappropriate incentives to order or provide arguably unnecessary services and to overcharge for the services that they do provide.

The reform of the incentives in the traditional fee-for-service system has been the predominant cost containment strategy for the last thirty years, following the advent of the Medicare and Medicaid programs in 1965. These programs adopted the fee-for-service system hook, line, and sinker. As a result, they

experienced tremendous inflation in program expenditures.⁹ It is important to understand that Congress incorporated the traditional fee-for-service approach into the Medicare program out of fear that physicians would not participate in the programs if there were other payment arrangements.¹⁰ Moreover, the Supplementary Medical Insurance Program (Part B)¹¹ was based on a health insurance proposal developed by the American Medical Association.¹²

Early reform efforts looked to the experience of existing HMOs, which were financed through pre-paid monthly fees from members and bore the risk of providing care to plan members. Specifically, HMOs had lower hospital utilization rates, offered more preventive services, and appeared to provide quality care in a more cost-effective manner.¹³ In 1972, Congress enacted the federal HMO Act in an effort to promote the development of HMOs nationwide.¹⁴

The move to managed care in the 1980s was primarily a private effort by health insurers and their major customers — employers — to control escalating health care costs. The Carter Administration's efforts to enact national health insurance had failed. The Reagan Administration was promoting competition and the private payers' move to managed care was seen as a positive outcome of competition. The 1980s witnessed the expansion of HMOs and the development of preferred provider organizations (PPOs) through which payers contracted with providers for services at lower costs in return for a guaranteed volume of patients.

Managed care received a boost with President Clinton's decision to adopt managed competition as the major strategy for

9. Marian Gornick et al., *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, HEALTH CARE FIN. REV., Supp. 1985, 13, 42-45.

10. See ROBERT J. MYERS, MEDICARE 1 (1970) (reviewing the legislative history of the Medicare program and the compromises with the provider community that influenced Medicare program design); JUDITH M. FEDER, MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE 1 (1977) (reviewing the rationale for the basic design of the Medicare program).

11. 42 U.S.C. §§ 1395(w) (1994).

12. MYERS, *supra* note 10, at 51-72.

13. See, e.g., Sheldon Greenfield et al., *Variations in Resource Utilization Among Medical Specialties and Systems of Care: Results from the Medical Outcomes Study*, 267 JAMA 1624 (1992) (reporting study findings that HMOs have hospitalization rates that are 40% below fee-for-service plans).

14. Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e (1994).

health reform in his proposal for comprehensive health care reform in 1993.¹⁵ With federally mandated health reform apparently in the offing, providers and payers created a variety of managed care networks that could compete effectively under the reformed system.¹⁶ Even with the failure of federally mandated health reform, providers and payers have continued this trend as they scramble to compete effectively in the relatively unregulated health care market of the present day. The upshot of these developments is that Americans are increasingly likely to receive their health care services through managed health plans.

B. Managed Care and the Relationships Between Patients, Physicians, and Plans

Perhaps the most important feature of managed care plans, particularly from the perspective of the physician-patient relationship, is the confluence of the functions of providing and paying for health care services. Under many managed care plans, especially the most integrated plans, there has been a fairly consistent pattern of fusion of the traditionally independent roles of providing care and paying for care. This fusion has crucial implications for the physician-patient relationship and also for the development and resolution of patient grievances.

Specifically, the role of physicians and their relationships to patients and patients' health plans are different in managed care settings than in the traditional fee-for-service environment. These changes, which make the relationship between physicians and their patients more indirect financially and to some extent, even clinically, are perhaps the most important changes wrought by managed care from the perspective of both patients and their physicians. At the heart of the changes is the ability and inclination of physicians to perform their crucial patient advocacy function. In the past, physicians as patient advocates felt obliged to seek the highest quality care for their patients in the absolute sense, almost independent of other considerations.¹⁷ There is some question whether physicians feel this obligation as in-

15. H.R. 3600, Health Security Act of 1993, 103rd Congress, 1st Session (1993).

16. See, e.g., Robert Pear, *Health Industry is Moving to Form Service Networks*, N.Y. TIMES, Aug. 21, 1993, at A1.

17. See Avedis Donabedian, *Quality, Cost, and Clinical Decisions*, 468 ANNALS AM. ACAD. POL. & SOC. SCI. 196, 199-204 (1983).

tensely today when operating under incentives to constrain resources and, thus medical care, to individual patients.

The changes in the relationship among physicians, their patients, and the patients' health plans, can be placed on a continuum. At one end of the continuum is the direct relationship between the physician and the patient. The patient is insured under a traditional indemnity insurance plan and the physician has no legal relationship to the patient's health plan. The contractual relationships are between the patient and the physician and the patient and the plan. The patient is obligated to pay the physician a fee for service rendered. The plan is obligated to indemnify the patient for medical expenditures incurred according to the terms of the insurance contract. Patients may and often do "assign" their rights to providers to collect payment from the plan.

At the other end of the continuum are more integrated managed care networks in which physicians have a contractual relationship with the plan and may indeed be the plan's employees. The legal relationship between the patient and the physician is more elusive. The patient, or an employer, union, or other payor on the patient's behalf, contracts with the plan and not with the physician for health care services. The physician, as the employee of or contractor with the plan, then provides health care services to the patient on behalf of the plan. Ostensibly, the patient has no contractual relationship with the physician, although, of course, the physician's obligations in tort remain.

The points on the continuum between these poles are also instructive. They include various types of HMOs, such as the group model HMO in which physician groups provide services to HMO members pursuant to a contract with the HMO, and the independent practice association (IPA) in which the HMO contracts with individual physicians. More recently, payor- and provider-sponsored networks have been organizing physicians to provide medical care. The predominant model for the organization of physicians in these networks is the physician-hospital organization (PHO), in which hospitals and their medical staffs bear the risk of care to network patients. Near the other end of the continuum, PPOs impose some restrictions on physicians, such as utilization review and cost constraints, in return for guaranteed patients.

An important confounding variable in all of these organizational arrangements is the extent to which the physician shares in the risk of the cost of caring for patients and the profit of excess

revenues from the care of patients. To the extent that physicians participate in the distribution of these excess revenues and bear some of the risk for their loss, whether in a for-profit or not-for-profit structure, they have a financial interest in limiting care to patients. This financial interest may pose ethical issues for physicians in the determination of care for these plan patients.¹⁸

Further, these issues are essentially the same regardless whether the corporate control of the organization is for-profit, not-for-profit, tax-exempt, or not-for-profit. The corporate control arrangements simply dictate where the excess revenues over expenses go. They do not directly address the relationship between the patient and physician.

In any event, that obligations follow payment is indisputable.¹⁹ Once the functions of providing and paying for care are fused, as is the case under many, if not most, managed care arrangements, then changes in the physician-patient relationship inevitably result. First, the physician now owes duties as contractor and/or employee to the plan. Second, the physician often has no real economic relationship to the patient, but rather, has an economic relationship chiefly to the plan and its sponsor. In some cases the plan rather than the patient selects the patient's physician, and in nearly all plans, constrains the choice of physicians available to the patient.

What is the impact of these changes on the physician's loyalty to the patient and the physician's function as the patient's advocate for care irrespective of cost or other constraints? It seems inevitable that the physician's traditional role of patient advocate for high quality care regardless of other considerations would be compromised.²⁰ Physicians now owe some loyalty to or at least are influenced by the corporate plans in which they practice. Maybe the American Medical Association was on to something in 1912 when it issued its first ethical canon on the corporate practice of medicine.²¹ Historically, the medical profession

18. See David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141 (1995).

19. See Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604 (1995).

20. See generally Carl H. Hitchner et al., *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273 (1994) (describing the different organizational models for integrated delivery systems along the continuum described in this Article).

21. See Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 459-462 (1995)

and its representatives have opposed practice settings in which physicians provided services where patients were not directly responsible for payment for the specific service rendered.²²

III. CURRENT LEGAL RULES FOR THE RESOLUTION OF GRIEVANCES

There are several, often conflicting, sets of state and federal legal rules that now govern the adjudication of grievances in managed care settings.²³ Which set of legal rules applies in a given situation depends on two major factors: (1) the sponsor of the plan; and (2) the nature of the dispute.

A. The Sponsor of the Plan

1. Government Programs

If the sponsor of the plan is the government, as is the case for Medicare and Medicaid, then the procedural due process guarantees of the Federal Constitution apply.²⁴ Procedural due process requires public health insurance programs to provide administrative hearing opportunities to beneficiaries who have disputes with the plan and adequate notice of plan decisions giving rise to such disputes.²⁵

For the Medicare program, Congress has mandated hearing procedures for patient disputes generally.²⁶ Congress also specified that hearing procedures be provided to patients of Medicare HMOs.²⁷ For the Medicaid program, Congress simply required

(recounting the history of the AMA's ethical position on the corporate practice of medicine).

22. *Id.* at 445. See also Sheva J. Sanders, *Regulating Managed Care Plans under Current Law: A Radical Reversion to Established Doctrine*, 20 HOFSTRA L. REV. 73 (1991) (reviewing the corporate practice of medicine doctrine in the United States which proscribed corporate ownership of medical practice and corporate employment of physicians).

23. See generally Eleanor D. Kinney, *Protecting Consumers and Providers Under Health Reform: An Overview of the Major Administrative Law Issues*, 5 HEALTH MATRIX 83 (1995) (discussing adjudicative procedures at both the state and federal level).

24. *Id.* at 89-91.

25. For a classical discussion of procedural process requirements for administrative hearings, see Henry Friendly, *Some Kind of Hearing*, 123 U. PA. L. REV. 1267 (1975).

26. 42 U.S.C. § 1395ff (1994). See Kinney, *supra* note 23, at 99-103; Eleanor D. Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L. J. 1 (1987).

27. 42 U.S.C. § 1395mm(c)(5) (1994); 42 C.F.R. §§ 417.600-638 (1996). See Kinney, *supra* note 23, at 100; Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674, 1691-92 (1994).

the states to provide opportunities for fair hearings which meet federal constitutional due process requirements.²⁸ Federal regulations require Medicaid HMOs to maintain "an internal grievance procedure" which provides for prompt resolution of disputes, and "the participation of individuals with authority to require corrective action."²⁹ Otherwise, Medicaid HMO members use the state's fair hearing procedures for all Medicaid disputes.³⁰

2. Private Health Plans

There are two basic sets of legal rules that apply to grievance procedures in private health plans: (1) state tort and contract law; and (2) the Employee Retirement Income Security Act of 1974 (ERISA).³¹ The definitive factor in determining which set of rules applies is whether or not the health plan is an "employee welfare benefit plan" under ERISA.³² In the event that it is an "employee welfare plan," then ERISA preempts state laws, including state insurance codes that might otherwise regulate employee benefit plans.³³

Generally, a self-insured employee health plan clearly will fall under the ERISA preemption and be subject to ERISA requirements. However, if the employer purchases health insurance from a commercial insurance company, aspects of the health plan that relate to the business of insurance may be regulated by state insurance laws.³⁴ The extent of the ERISA preemption has been controversial, as has the fact that it insulates employee benefit plans, particularly those which are self-insured, from the consumer protections under state insurance codes that customarily regulate commercial health insurance plans, Blue Cross and Blue Shield plans, and HMOs.³⁵ For self-insured employee health

28. 42 U.S.C. § 1396a(a)(3) (1994); 42 C.F.R. §§ 431.200-250 (1993).

29. 42 C.F.R. § 434.32(c) (1994). See Kinney, *supra* note 23, at 103.

30. See Stayn, *supra* note 27, at 1701-08 (noting weak structural protections in many states for non-Medicare enrollees with grievances).

31. 29 U.S.C. §§ 1101-1461 (1994).

32. 29 U.S.C. § 1002(1) (1994) (defining employee welfare benefit plans).

33. *Id.* § 1144.

34. *Id.* § 1144(b)(2)(A); see *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (ordering removal to federal court where suit was not based on a law regulating insurance but based on laws pre-empted by ERISA); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987) (noting that laws regulating insurance are excepted from pre-emption clause laws).

35. See, e.g., Mary A. Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255 (1990); Alan I. Widiss & Larry Gostin, *What's Wrong with the ERISA "Vacuum?": The Case Against Unrestricted Freedom*

plans, ERISA sets forth the procedures for resolving grievances.³⁶ These ERISA procedures do not specifically address disputes that arise in capitated systems outside the context of claims related to payments for fee for services.³⁷

For health plans subject to regulation under state insurance codes, the codes do apply along with principles of state contract and tort law. For conventional health plans regulated under state law, consumer disputes are generally adjudicated in state courts as matters of state contract law as modified by state statutory and common laws governing insurance.³⁸ In recent years, the emerging common law tort theory of bad faith breach of contract has become an important basis for recovery against state-regulated health plans that fail to pay claims.³⁹ It should be noted that the Supreme Court has ruled that recovery of damages on this theory is not available for disputes with any employee benefit plans regulated under ERISA.⁴⁰

States also specifically regulate HMOs with statutes setting forth requirements for HMOs offering services within the state.⁴¹ Most of these statutes require HMOs to maintain internal grievance procedures for consumers.⁴² Further, most states require HMOs to advise consumers of these procedures upon enrollment or even upon material changes in the benefit package offered by the HMO.⁴³ However, if the HMO is a self-insured employee benefit plan regulated under ERISA, these protections under state law do not apply.

for Employers to Terminate Employee Health Care Plans and to Decide What Coverage is to be Provided When Risk Retention Plans are Established for Health Care, 41 *DRAKE L. REV.* 635 (1992) (discussing ERISA's preemption of many state attempts at regulating employee health plans).

36. 29 U.S.C. § 1132 (1994). See Kinney, *supra* note 23, at 96-98.

37. Kinney, *supra* note 23, at 96-99.

38. *Id.* at 96, n.55.

39. *Id.* at 96, n.56.

40. *Pilot Life Ins. Co.*, 481 U.S. at 52-54 (1987).

41. See Barbara A. Shickich, *Legal Characteristics of the Health Maintenance Organization*, in *HEALTHCARE FACILITIES LAW: CRITICAL ISSUES FOR HOSPITALS, HMOs, AND EXTENDED CARE FACILITIES* § 16.9, at 1079-81 & n.1 (Anne M. Dellinger ed., 1991) (listing state statutes regulating HMOs).

42. Stayn, *supra* note 27, at 1703 n.203 (listing applicable state statutes).

43. *Id.* at 1704 n.206 (listing applicable state statutes).

B. The Nature of the Dispute

The other distinguishing factor in determining applicable legal rules for adjudicating disputes under current law is the nature of the issues in dispute. Disputes between consumers and their providers and payers fall under four substantive areas: (1) eligibility for services; (2) the amount of payment for services; (3) coverage of services; and (4) poor quality of services resulting in medical injury.

Under traditional fee-for-service plans, the legal rules for the disposition of disputes in each of these substantive areas are quite distinct. Claims in the first three categories, such as eligibility, payment, and coverage of services, are adjudicated as claims against the health plan in the applicable appeals systems outlined above.⁴⁴ Tort claims for bad faith breach on the part of a payor or plan also exist for egregious conduct resulting in the denial of payment or coverage in the case of state-regulated, private insurance, and HMO plans.⁴⁵ Claims regarding quality of services that result in medical injury are resolved in state common law tort systems under principles of medical malpractice law.

Historically, patient grievances with both private and public health insurance programs have centered primarily around payment for and coverage of services. These issues also arose in the context of a "claim." Quality disputes based on negligence, for example medical malpractice, are completely distinguishable and handled independently in the common law tort system. Only to the extent that the payor was also at risk for providing services, as in an HMO, did the patient have grievances with the plan about the quality of services.

However, as a result of the confluence of the provision and payment of services in many managed care plans, the legal systems for adjudicating disputes under these plans now overlap. The old legal authorities for resolving grievances between patients and their physicians and payors have not kept pace with the emerging models of providing and paying for care or the resulting reconfiguration of issues giving rise to grievances.

The major problem with the confluence of providing and paying for health care in managed care plans pertains to cover-

44. 29 U.S.C. § 1144 (1994).

45. *Id.*

age decisions. Specifically, under traditional payment arrangements in which payors paid for all service ordered unless specifically not covered, coverage disputes were generally clearly delineated. For one reason, the physician, as the patient's advocate, would order a service and the payer would refuse to pay for it on grounds that it was not covered under the plan. This refusal constituted a distinct event that triggered the appeal. But now, many managed care plans impose financial or other incentives on physicians not to order services, so the physician may simply determine not to provide a service to a patient, often without indicating that the service is ostensibly available in the arsenal of medical treatment modalities. The patient does not know that a coverage determination has been made or that an appealable event has occurred.

Other anomalies are present with the confluence of providing and paying for care. Perhaps no other legal development exemplifies the untoward implications of the confluence of providing and paying for care than the treatment of malpractice claims against ERISA-regulated health plans. In recent years, patients who have sued ERISA-regulated managed care plans have often encountered court decisions ruling that their common law malpractice claims against plans are preempted by ERISA and state common law remedies against the plan are, therefore, unavailable.⁴⁶ Generally, only those claims that involve plan supervision of medical care which result in physical injury as well as claims directed at plan physicians for medical negligence are preempted.⁴⁷ Most courts have preempted under ERISA tort claims aimed at plan cost containment policies.⁴⁸ Then, the extension of tort liability to managed care plans and the appropriate range of the ERISA preemption remain controversial.⁴⁹

For purposes of designing systems to resolve grievances, the confluence of paying for and providing services within a plan

46. See William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 485-92 (1991) (describing cases in which courts ruled that ERISA preempted medical malpractice and other state tort claims against managed care plans).

47. *Id.* at 489-92.

48. *Id.* at 487-88.

49. See, e.g., Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L. J. 1297, 1311 (1994); Helene L. Parise, Comment, *The Proper Extension of Tort Liability Principles in the Managed Care Industry*, 64 TEMP. L. REV. 977, 1003 (1991).

profoundly changes the appeals process. In a managed care plan, the crucial action defining the appealable event becomes the clinical decision of the physician regarding the amount, duration, and scope of services provided to the patient. When the clinical decision becomes the appealable event, it is difficult to distinguish a coverage dispute from a quality dispute giving rise to a medical malpractice claim. Indeed, as a result of the fusion of providing and paying for care, malpractice and claims for coverage of or payment for medical services, once independent decisions, now overlap. In designing grievance procedures and appeals systems for managed care plans, it is crucial to address these ramifications of the confluence of providing and paying for care that now confront patients as they protect their interest in receiving quality care from these plans.

IV. RESOLVING GRIEVANCES IN MANAGED CARE PLANS

A. Design Issues

1. The definition of the appealable event

Traditionally in administrative law analysis, rights, and remedies flow from definitive events. From a design perspective, problems emerge when legal rights are not grounded in defined events, that is, the claim. In HMOs and managed care plans, as opposed to traditional fee-for-service plans, services are not paid for on an individual basis and thus there are no specific "claims" presented to payors for payment for services.

What is the appealable event, if it is not a claim? What is the appropriate appealable event when an HMO or other prepaid managed care plan terminates or does not provide requested services? To the extent that the appealable event becomes a medical decision independent of payment for services, how is it distinguished from malpractice? The issue of the appealable event is one of the most difficult to address in designing grievance procedures under managed care plans. It is noteworthy that this proved to be an especially confounding issue for consumer groups in the recent debate over health care reform.⁵⁰

50. See Kinney, *supra* note 23, at 131-32.

The crucial problem is how to identify an appealable event, given the reality of a medical practice that requires physicians to choose among an array of treatment modalities for various medical problems. Conceivably, every decision that a physician makes could constitute an appealable event. Clearly such an eventuality would impede the frank and open physician-patient relationship required for a sound therapeutic environment. At what point do determinations of medical appropriateness or necessity merge with clinical decision-making? For example, a physician may decide that, although a service is covered, it is not medically necessary or appropriate for a given patient. In a capitated system, incentives exist for physicians to make clinical judgments that limit the provision of covered benefits and these incentives could encourage physicians to find services unnecessary or inappropriate.

This issue is compounded when a health plan makes a corporate policy decision, presumably to be more competitive from a cost perspective, to define medical necessity for particular conditions at levels less than is customarily provided under current practice. Such policies would presumably be based on clinical practice guidelines and be accompanied by efforts to get plan subscribers to agree by contract to accept the medical practice guideline as the applicable standard of care for malpractice purposes.

There are some models in the current appeal procedures for Medicare HMOs that could serve to define triggers for appeals. Specifically, Medicare uses an initial determination concept that activates grievances and appeals in Medicare HMOs.⁵¹ The Medicare statute requires Medicare HMOs to "provide meaningful procedures" for hearing and resolving consumer grievances.⁵² A Medicare enrollee who is "dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay" has a right to administrative and judicial review under the Social Security Act.⁵³ However, only disputes that fall within the definition of an "organizational determination" are eligible for administrative and judicial review. These determinations are HMO de-

51. See Kinney, *supra* note 23, at 100-01.

52. 42 U.S.C. § 1395mm(c)(5)(A) (1994).

53. 42 U.S.C. § 1395mm(c)(5)(B).

cisions to deny access to treatment within the HMO, deny authorization for an outside referral for covered services, or deny payment for emergency, urgent, or other care provided outside the HMO.⁵⁴ All other issues, including disputes over quality, are "grievances" to be handled in the HMO's internal grievance procedure.⁵⁵

Another source of models for addressing this issue is the comprehensive health care reform proposals introduced in the 103d Congress.⁵⁶ In President Clinton's proposal, claims were the events that triggered appeals and were defined as "claims for payment or provision of services. . . ." or "a request for preauthorization of items or services" submitted to a health plan.⁵⁷ Senator Mitchell's compromise bill included an additional provision that expanded the definition of appealable event to encompass the "denial, reduction or termination of any service or a request for a referral or reimbursement."⁵⁸

2. Grievance Procedures

Health plans need grievance procedures to handle complaints of individual consumers. The grievance process should commence with an informal meeting led by responsible plan personnel with authority to make the requisite decisions to correct mistakes or obtain medical or other information that could resolve the dispute. In this meeting, the plan representative should try to resolve the dispute and advise the consumer of future steps in the appeals process. The health plan should provide the consumer with a written decision and notice of further appeal steps.

Should there be an appeal procedure from the plan grievance procedure at all and, if so, what types of issues should be eligible for further process? For example, as noted above, the Medicare HMO appeal procedures do distinguish between issues that are eligible for more formal process, such as administrative

54. 42 C.F.R. § 417.606(a) (1994). See Stayn, *supra* note 27, at 1691.

55. 42 C.F.R. § 417.600 (1994) (defining organization determinations). See Stayn, *supra* note 27, at 1691.

56. See generally Timothy S. Jost, *Administrative Adjudication Under Health Care Reform*, 47 ADMIN. L. REV. 425 (1995) (discussing administrative adjudication issues raised in proposals by the 103d Congress).

57. H.R. 3600, The Health Security Act of 1993, 103d Cong., 1st Sess. § 5201(a)(1) (1993). See Kinney, *supra* note 23, at 127.

58. S. 2560, Health Security Act, 103d Cong., 2d Sess. § 5501 (1994). See Kinney, *supra* note 23, at 128.

and judicial review, and a simple grievance procedure at the HMO level.⁵⁹

If more formal process is appropriate, it is not clear that one particular model of dispute resolution, such as mediation or arbitration, is inherently more effective than another mode, such as a traditional administrative hearing. It is interesting to note that President Clinton's health care reform proposal called for a choice of approaches, including alternative dispute resolution, traditional administrative review, or judicial lawsuit, following a grievance procedure, presumably to give consumers a choice of procedural routes to pursue relief.⁶⁰

Any procedure is appropriate *provided* that certain procedural elements are present. There are four key elements. First, there should be timely notice that appealable events have occurred and of the procedures for appeal. This includes notice of applicable medical practice guidelines that govern coverage of services under the plan.

Second, there should be prompt decisions by a knowledgeable, unbiased decision maker. In any adjudication system, speed and expertise in the decision-making process are key to providing genuine relief.

Third, large areas for the exercise of discretion should be accorded to the decision maker. While this may be counter intuitive, decision makers need to have the latitude to provide satisfactory relief to a patient, if appropriate. Hard and fast rules not only impose constraints on the clinical decision making of physicians within the plan, but also on decision makers resolving disputes and seeking to protect the legitimate interests of patients in receiving quality care.

Finally and perhaps most importantly, there should be methods for empowering patients in the grievance process. This is a troubling issue given the inherent disparity in power and expertise between patients and plans. A grievance procedure should be informal and comprehensible enough so that grievances can be negotiated by the patient individually. However, a patient should have the option to be represented by counsel or other types of representative in order that their cases be presented effectively.

59. 42 U.S.C. § 1395mm(c)(5)(B) (1994).

60. H.R. 3600, 103d Cong., 1st Sess. §§ 5201-5243 (1993). See Kinney, *supra* note 23, at 127-28.

A crucial issue with respect to alternative dispute resolution procedures such as mediation or arbitration is the degree to which patients are genuinely situated to use these procedures effectively to protect their interests *vis-à-vis* the health plan. Alternative dispute resolution procedures in lieu of court proceedings that are imposed on patients as a matter of contract upon enrollment in the plan are especially suspect as they, by definition, eliminate a range of judicial protections with which patients are presumably familiar. Alternative dispute resolution procedures also compromise the interest of patients if they either limit the patient's rights to obtain relief under prevailing common law legal theories or they impose procedures, such as limits on representation by counsel, that disadvantage the patient procedurally.

3. Judicial Review

A central issue is the degree to which consumers and providers may challenge decisions and policies of a health plan in state or federal court. To many consumers and providers, judicial review is perceived as the ultimate forum for assuring accountability of government or corporate actors. Further, courts have played a strong role in protecting rights of consumers with respect to government entitlement programs in the past.⁶¹ We would not do badly to leave current remedies, such as the right to sue state personnel for violations of the Federal Constitution under Section 1983⁶² in place.⁶³ Clearly, however, some modification of ERISA limits on common law remedies to recover in tort would be appropriate.

B. Strategies for Avoiding Grievances

This Article closes with some suggestions for avoiding grievances altogether—an approach that best serves the interest of patients. First, support the physician's traditional, best role as advocate for the patient in the development of coverage policy for the plan and give plan physicians authority to make coverage policy through a credible process. Patients are more likely to

61. See generally Rand E. Rosenblatt, *The Courts, Health Care Reform, and the Reconstruction of American Social Legislation*, 18 J. HEALTH POL., POL'Y & L. 439 (1993) (defending the court's rights-enforcing role in health care reform).

62. Civil Rights Act of 1871 § 1, 42 U.S.C. § 1983 (1994).

63. See Kinney, *supra* note 23, at 104-08.

support a scientifically based coverage policy that their physicians support even if it results in denials of care. Second, provide patients with comprehensible information about plan benefits and coverage policy. In doing this, they will not be surprised when a denial of care occurs and will be less likely to object to that denial.

Third, give particular attention to the problem of caring for the chronically ill. This population will have many encounters with plans, is knowledgeable about available and new treatments, and is generally motivated to seek good care. Finally, health plans should be sure to provide high quality care. While this advice may seem self-evident, it is crucial. In the final analysis, grievances and disputes of whatever nature will be avoided if the health plans provide high quality care.

The case of diabetes is instructive of how following these principles could avoid patient grievances. Recently, a ten-year clinical trial funded by the National Institutes of Health demonstrated quite definitively that aggressive regulation of blood sugar — a costly endeavor — prevents the devastating and costly complications of diabetes that can develop in the years following diagnosis.⁶⁴ Yet, this treatment may not be cost-effective for a health plan that only has responsibility for a patient for a few years and probably will *not* experience the benefits of reducing the high medical expenditures associated with caring for the complications of diabetes that generally follow many years later. Only health plans with a commitment to the long-term welfare of the patient and the ability to meet this commitment in a competitive health care environment will be able to benefit from providing this high level care for patients with diabetes. The situation is no doubt similar to other chronic diseases, and there is evidence that managed care plans to date have fallen short in providing high quality care for the chronically ill.⁶⁵

Application of these four principles to avoid grievances by patients regarding treatment for their diabetes might play out as

64. The Diabetes Control and Complications Trial Research Group, *The Effect of Intensive Treatment of Diabetes on the Development and Progression of Long-Term Complications in Insulin-Dependent Diabetes Mellitus*, 329 NEW ENG. J. MED. 977 (1993) (describing the beneficial effects of rigorous treatments for diabetes).

65. See, e.g., Teresa Fama et al., *Do HMOs Care for the Chronically Ill?*, HEALTH AFF., Spring 1995, at 234; Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations*, 321 NEW ENG. J. MED. 86 (1989).

follows. Plan physicians should formally consider the best medical evidence regarding the treatment of diabetes including extant medical practice guidelines or other standards that address the treatment of diabetes.⁶⁶ Plan physicians might affirmatively adopt guidelines with which they agree as a matter of plan policy and make this policy available to potential enrollees. Plans would then aggressively support plan physicians as they follow these guidelines and generally provide high quality care to patients with diabetes. By following these principles, plans would inevitably provide higher quality care which would satisfy diabetic patients receiving the care. Informed patients would be assured that the care comported with the state of the art of medical practice in the field. Satisfied patients who know that they have been accorded care meets the scientifically based guidelines are clearly less likely to have a grievance about the care they received.

VI. CONCLUSION

Resolving grievances after the fact—which always has been an unsatisfactory approach—may also prove especially deleterious in a managed care environment. The greatest hope for protecting consumers lies in the avoidance of grievances and disputes in the first instance. While this principle is always true, it is especially true in a managed care context. However, achieving this goal may be difficult to accomplish in an era of frenetic cost cutting and industry shake-down. Consequently, having fair procedures in place that accommodate the realities of delivering care in managed care settings is essential. Fair procedures that empower patients are also crucially important in today's health care system where so many forces are at work to disempower consumers in the health care context and society generally.

66. Charles M. Clark & Eleanor D. Kinney, *Standards for the Care of Diabetes: Origins, Uses and Implications for Third-Party Payment*, 15 *DIABETES CARE* 10 (Supp. 1992) (discussing the extant medical practice guidelines regarding the treatment of diabetes).

